Healing Cedar Wellness

Traditional Chinese Medicine and Acupuncture Intake Form

Rebecca Stephens, Dr.TCM, R.Ac., B.Sc.

To assist in providing you with the best possible care, please fill out this form as accurately as you can. All the information provided will be kept confidential in your patient's file.

PATIENT INFORMATION

NAME:		TODAY'S DATE:
DATE OF BIRTH:	AGE:	SEX: M F T
HOME ADDRESS:		POSTAL CODE:
HOME PHONE:	MOBILE PHONE:	
EMAIL:	OCCUPATION:	

EMERGENCY CONTACT:	PHONE:	RELATIONSHIP:
FAMILY PHYSICIAN:	PHONE:	NAME OF CLINIC:
Are you currently under a physician's care? YES NO	If YES, for what?	
List all prescription medications currently taking (with dosage if possible):		
List all non-prescription medications or supplements currently taking:		

REASONS FOR TODAY'S VISIT TO OUR CLINIC

CONCERN	**HOW LONG HAS THIS BEEN AN ISSUE?**
1.	
2.	
3.	

Please indicate any other current or pervious therapies for these concerns:
□ Massage Therapy □ Physical Therapy □ Chiropractor □Medical □ Other_____

How did you hear about the clinic and Dr. Rebecca Stephens?
□ Internet search □Walk by □ Family/Friend referral □ Other Health Practitioner Referral

Please provide name and designation of source of referral, if referred by another Health Practitioner:

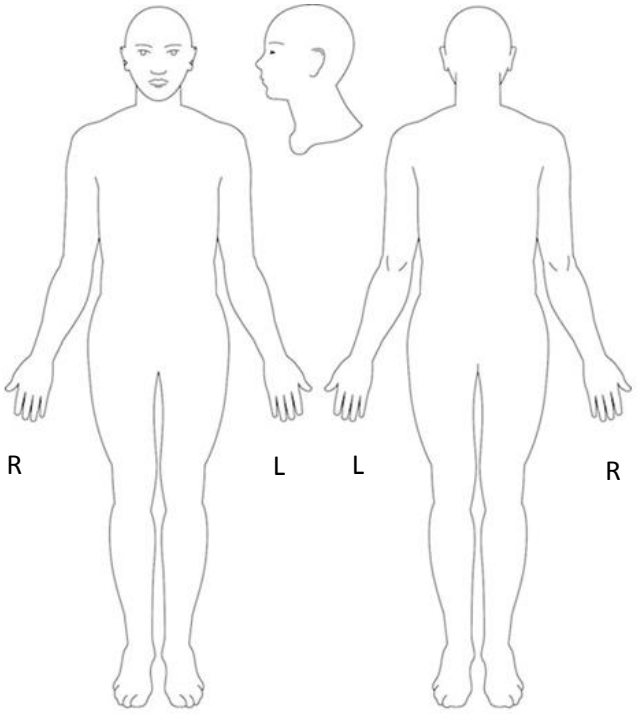
_____

Is this your first time with Acupuncture or Traditional Chinese Medicine (TCM)? YES NO

If **no**, what have you previously received Acupuncture/TCM treatment for, and when?

_____

On the figures below, please indicate and code your areas of pain/concern:



P – pins and needles
N – numbness
S – spasm
T – tenderness
A – aches
R – radiation
B – burning
X – stabbing
O – other (describe)
_____

GENERAL

HEIGHT:	WEIGHT:

Are you physically active?	How many times do you exercise/week?
Briefly describe your diet, or indicate if you are on a special medical diet:	

PERSONAL MEDICAL HISTORY

Past and current medical diagnosis (given by certified medical professional), include date diagnosed	
List all allergies and sensitivities:	
History of hospitalizations, surgeries, significant illnesses, or injuries (what for, date):	
Are you scheduled for an upcoming surgery? If so, when and for what?	
Do you have a pacemaker?	Do you have any metal implants? (e.g. plate and screws)

Please check any of the following **conditions** that you currently suffer from, or have a medical history of:

- ○ anemia
- ○ angina
- ○ arthritis
- ○ asthma
- ○ cancer
- ○ chronic fatigue
- ○ diabetes
- ○ deep vein thrombosis
- ○ emotional problems
- ○ epilepsy
- ○ fibromyalgia
- ○ gall stones
- ○ glaucoma
- ○ irregular pulse
- ○ heart disease
- ○ bleeding disorders
- ○ hepatitis A
- ○ hepatitis B
- ○ hepatitis C
- ○ high blood pressure
- ○ HIV/AIDS
- ○ kidney disease
- ○ kidney stones
- ○ liver disease
- ○ low blood pressure
- ○ mental illness
- ○ migraines
- ○ multiple sclerosis
- ○ osteoporosis
- ○ fractures
- ○ respiratory disease
- ○ gastrointestinal
- ○ skin conditions
- ○ spinal injury
- ○ fainting episodes
- ○ stroke / ITA
- ○ thyroid problem
- ○ tuberculosis
- ○ ulcers
- ○ varicose veins

Other (please specify):

Symptom Checklist (please check all that apply):

- ○ always feeling cold
- ○ always feeling hot
- ○ abnormal sweating
- ○ addictions
- ○ allergies
- ○ anxiety / stress
- ○ apathy
- ○ asthma
- ○ bad breath
- ○ bad taste in mouth
- ○ bleeding gums
- ○ blood in stool
- ○ blood in urine
- ○ brittle hair/nails
- ○ bruise easily
- ○ chest pain
- ○ chronic cough
- ○ chronic runny nose
- ○ cloudy urine
- ○ constant thirst
- ○ constipation
- ○ depression
- ○ diarrhea
- ○ difficulty concentrating
- ○ dizziness
- ○ dry mouth/throat
- ○ dry skin
- ○ easily angered
- ○ edema
- ○ fatigue
- ○ fevers
- ○ floaters in eyes
- ○ foggy thinking
- ○ frequent urination
- ○ gas/bloating
- ○ hair loss
- ○ headaches/migraines
- ○ hearing problems
- ○ heartburn/acid reflux
- ○ heat in palms/soles
- ○ hemorrhoids
- ○ high libido
- ○ infertility
- ○ insomnia
- ○ irritability
- ○ loose stools
- ○ low appetite
- ○ low back pain
- ○ low immune system
- ○ low libido
- ○ mouth/tongue sores
- ○ mucous in stool
- ○ muscle tension/spasm
- ○ nausea/vomiting
- ○ neck pain
- ○ night sweats
- ○ palpitations
- ○ poor circulation
- ○ poor memory
- ○ post nasal drip
- ○ problems with weight
- ○ redness in eyes
- ○ restless leg
- ○ ringing in ears
- ○ shortness of breath
- ○ skin discolorations/moles
- ○ swollen lymph nodes
- ○ tightness in chest
- ○ urinary incontinence
- ○ urinary tract infection
- ○ vision problems
- ○ water retention

Other (please specify):

WOMEN'S HEALTH (*marks required fields):
PREGNANCY:

***Is there any chance you are currently pregnant?** **YES NO (if YES, at _____ weeks)**	When is your due date?	Is this your first pregnancy?
Are you carrying twins or multiples?	Is there known breech presentation?	
If pregnant, are there any concerns or complications with this pregnancy?		
If pregnant, are there any symptoms you are experiencing?		

GYNECOLOGY:

***Are you trying to conceive?** **YES NO**	Age when you had your first period	Age when you underwent menopause (if applicable)
Is your period regular?	Length of menstrual cycle (eg "28 days")	***What day of your cycle are you on?**
On what day do you ovulate?	Is there any bleeding between periods?	Average length of flow/bleeding

Is your period flow (circle): Very heavy Heavy Average Light Very light	Is the colour of the flow (circle): Brown Purple Dark red Red Light red	Are there clots? YES NO

Do you use birth control? If so, what form?	Do you have any bleeding between periods? YES NO	Do you have any abnormal discharge not associated with your period? YES NO

Have you had any pregnancies? How many?	How many children do you have, and how old are they?
Have you had problems with pregnancy? Please explain:	Have you had any miscarriages? Please provide dates:
List any current menstrual symptoms (e.g. PMS, cramps, breast distension, water retention, headaches, nausea, etc)?	
List any current menopausal symptoms (e.g. hot flashes, night sweats, insomnia, etc)?	
Any history of sexually transmitted infections? If so, please indicate what and when:	
Date of last PAP smear, and if any abnormal findings:	
Do you have any other women's health concerns? Please specify:	

MEN'S HEALTH:

Do you have any problems with (please circle):		
decreased libido	ejaculation disorders	difficulty urinating
infertility	testicular pain	urinary incontinence
erectile dysfunction		prostate enlargement
Any history of sexually transmitted infections? If so, please indicate what and when:		
Date of last prostate exam, and if any abnormal findings:		
Do you have other men's health concerns? Please specify:		

Thank you for taking the time to fill out this form thoroughly and to the best of your knowledge. Please note that, for your convenience, if you are seeing more than one practitioner at Healing Cedar Wellness this intake form may be shared.

INFORMED CONSENT

Please read the following information carefully, and ask your practitioner if you have any questions:
The Traditional Chinese Medicine (TCM) practises of acupuncture, electro-acupuncture, moxabustion, cupping, gua-sha, and tuina are considered to be very safe and effective treatments. Your practitioner may use one or many of these techniques in the course of your treatment. It is important that you inform your practitioner of all health conditions (including pregnancy) and medications, as some of these techniques could be inappropriate or require modification in these circumstances.

Acupuncture involves the insertion of sterile, single-use, disposable needles to specific points on the body to achieve therapeutic effect. Please be aware that you should not make any significant movements while these needles are being applied, retained, or removed. **Electro-acupuncture** is the addition of a mild electric pulse to these points to increase point stimulation. **Moxabustion** is the application of indirect heat by burning a stick of compressed *Artemesiae vulgaris* (commonly known as Mugwort), over acupuncture points as an alternative or addition to stimulate meridian circulation. **Cupping** involves the application of round suction cups (made of glass, plastic, or silicone) over muscle area to enhance blood circulation to the area. **Gua-Sha** is best described as a "scraping technique", where friction is applied to areas of skin to enhance the dermal circulation. **Tuina** is a form of physical manipulation where pressure or massage techniques are applied to points on the body. Please be aware that an infra-red heat lamp is often used during treatment, both to keep exposed parts of the body warm during treatment, as well as to apply heat therapy to areas of the body. The treatment tables also have heating pads on them, to increase your comfort during treatment.

As with any therapy, there are some risks and possible side-effects to these treatments to be aware of:
Residual needle sensation – there may be a residual sensation at the point of insertion that may last for a period of time after the needles have been removed. This can be common if strong stimulation has been achieved. Please advise your practitioner if this does not dissipate in 1-2 days
Drowsiness or dizziness – please ensure that you eat and drink before treatment, as these effects may be more common if your blood sugar is low, or if you are dehydrated. It is also recommended that you do not drive or operate equipment immediately after treatment if you are feeling dizzy or lightheaded.
Fainting – more likely again if you are hungry or dehydrated, or if it is your first acupuncture treatment. Please advise your practitioner if you are feeling faint.
Bruising, bleeding, or swelling – small amounts of bleeding (often 1 or more drops) are common to occur at the site of needle insertion. Bruising may also occur at the site of needle insertion. Both cupping and gua-sha commonly leave noticeable marks or bruises on the skin. Bleeding usually ceases within seconds, and any bruising that occurs usually dissipates within a few days to a week. Please advise a physician if any of these effects seem severe.
Temporary aggravation of symptoms – as with many types of healing, symptoms may sometimes worsen before improving. Please advise your practitioner if symptoms worsen for more than a few days.
Burning – this is possible with the use of a Mugwort stick in moxabustion, and also a risk with using an infra-red heat lamp close to the skin. Cupping with glass cups utilizes a small flame to create the vacuum within the cup, so burning is a possibility with this technique as well. Please advise your practitioner or a physician if it seems severe.

The **herbs** used in traditional Chinese medicine (which can be from plant, animal, or mineral source) that have been recommended for use are considered safe. Some of the herbs are inappropriate during pregnancy, or while taking other medications. It is important to inform your practitioner of all these situations and conditions, and to keep your practitioner up to date on any changes during the course of your treatment. Possible side effects to herbal therapy include such things as gastrointestinal upset or skin rashes. It is important to cease use immediately, and inform your practitioner, in the case of adverse reaction to herbal therapy. In the rare case of serious anaphylactic reaction, cease use and seek medical attention immediately.

Healing Cedar Wellness is an Integrated Health Clinic, and as such other practitioners working with you have access to your file. This information will only be viewed by the Practitioners you are seeing if and when appropriate. Practitioners also may have a Locum working in their place in circumstances (eg. vacation or illness) when they may be unavailable for your treatment. Every effort will be made to inform you of these circumstances at the time of booking.

STATEMENT OF CONSENT TO TREATMENT

As a patient of Rebecca Stephens and Healing Cedar Wellness, I _____have read the information and understand that this form of medical care is based on Traditional Chinese Medicine principles and practices. I am relying on my practitioner to exercise judgment during the course of my treatment, trusting that, based on the facts then known, this treatment plan is appropriate and in my best interests. I understand that these practices are not intended to be substitutes for treatment by a medical doctor. I know that at, at any given time during the treatment, I may request my practitioner to stop, modify, or change the treatment plan. I also know that I may decline treatment by a Locum if I so desire.

As Healing Cedar Wellness is an Integrated Health Clinic; I recognize that all the practitioners that are working with me may have access to my file and will ensure all information is private and confidential. I also recognize that even the gentlest therapies potentially have their complications, and hence the information provided must be complete and inclusive of all health concerns including pregnancy, significant medical history, and all medications (including over the counter drugs and supplements). I will inform my practitioner immediately if there is a possibility that I am pregnant. I understand that it is my responsibility to fully disclose all medications and supplements I may be taking, and refrain from mixing these medications with any prescribed herbal formulas.

Rebecca Stephens (Dr.TCM, R.Ac.) utilizes therapies as outlined by the theories of Traditional Chinese Medicine and Acupuncture; however, I do not expect Rebecca Stephens to be able to anticipate all of the risks and complications associated with this treatment. I have been informed that certain side effect reactions to treatment may occur, including such reactions as residual needle sensation, dizziness, fainting, bruising, bleeding, injury, temporary aggravation of symptoms, or other related reactions. I also fully understand that there are possible side effects to herbal therapy, and will cease use and inform my practitioner immediately if these occur.

I hereby request and consent to acupuncture treatments, herbal treatments, and other practices within the scope of Traditional Chinese Medicine on me by Rebecca Stephens. I intend this consent to also apply to a Locum working in her stead. I also confirm that I have the ability to accept or reject this care and treatment of my own free will and choice, and that I am not an agent of any private, local, provincial, or federal agency attempting to gather information without so stating.

I accept full responsibility for fees incurred during this care and treatment, and **agree to the cancellation policy of this clinic requiring 24 hrs notice for all cancelled appointments.** With this policy, I am aware that full price of appointment will be charged in the case of missed appointment or late (less than 24 hours) cancellation. I am also aware that if I show up late for my appointment, that my appointment will still end at the designated time, or that my appointment may be cancelled at my own cost if the Practitioner decides there is not enough time to properly complete a treatment.

Name (please print): _____

Signature: _____ Date: _____

Parental Consent (if under 18): _____

Witness: _____